KENTUCKY EMPLOYEES' HEALTH PLAN (KEHP)

2011 LEGAL NOTICES

As a member of the Kentucky Employees' Health Plan (KEHP), you have certain legal rights. Several of those rights are summarized below. Please read these provisions carefully so that you will understand your legal rights.

A. INITIAL NOTICE OF OPPORTUNITY TO ENROLL IN KEHP IN CONNECTION WITH EXTENSION OF DEPENDENT COVERAGE TO AGE 26

Individuals whose Kentucky Employees' Health Plan (KEHP) coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in KEHP. Individuals may request enrollment for such children for 30 days, beginning October 1st, 2010 and ends October 31st, 2010. KEHP 2011 Open Enrollment is October 11th and ends October 24th, 2010. Coverage will be effective January 1, 2011. For more information contact the Department of Employee Insurance (DEI) at 888-581-8834.

B. NOTICE OF KEHP DISCLOSURE OF GRANDAFTHER STATUS FOR PLAN YEAR 2011

This group health plan believes this plan, the KEHP, is a ''grandfathered health plan'' under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits and rescissions. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Personnel Cabinet, Office of Legal Services, General Counsel, Department of Employee Insurance. You may also contact the U.S. Department of Health and Human Services at *www.healthreform.gov.*

C. INITIAL NOTICE ABOUT HIPAA SPECIAL ENROLLMENT RIGHTS, NEW DEPENDENTS, AND PRE-EXISTING CONDITION EXCLUSIONS

A federal law called HIPAA requires that we notify you about two very important provisions in the plan. The first is your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons. Second, this notice advises you of the plan's pre-existing condition exclusion rules that may temporarily exclude coverage for certain pre-existing conditions that you or a member of your family may have.

1. Special Enrollment Provision Loss of Other Coverage.

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 35 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

2. New Dependent by Marriage, Birth, Adoption, or Placement for Adoption.

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 35 days after the marriage and within 60 days after birth, adoption, or placement for adoption.

As required by the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) effective April 1, 2009, the Kentucky Employees' Health Plan (KEHP) will permit employees and dependents who are eligible for a Child Health Insurance Program (CHIP) but not enrolled for coverage to enroll in that coverage under two scenarios: 1) The employee's or dependent's Medicaid or CHIP coverage is terminated as a result of loss of eligibility; 2) The employee or dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP. An employee must request this special enrollment within 60 days of the loss of coverage in the first scenario, and within 60 days of when eligibility is determined in the second scenario.

3. Pre-existing Condition Exclusion Rules.

This plan imposes a pre-existing condition exclusion for anyone over the age of 19. There are no pre-existing condition exclusions for dependent children under the age of 19. That means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period prior. Generally, this 6-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the 6-month period ends on the day before the waiting period begins. The pre-existing condition exclusion does not apply to pregnancy, domestic violence, genetic information in the absence of a diagnosis for such a condition.

This exclusion may last up to 12 months from your first day of coverage or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage (HIPAA Certificates) you have. If you do not have a Certificate, but you do have prior health coverage, we will help you obtain a Certificate from your prior plan or issuer. There are also other ways you can show that you have creditable coverage. Please contact DEI if you need help demonstrating creditable coverage.

All questions about the preexisting condition exclusion and creditable coverage should be directed to the Department of Employee Insurance, Member Services Branch. (888) 581-8834, (502) 564-6534 or http://personnel.ky.gov/dei/.

D. NOTICE TO ENROLLEES CONCERNING TOBACCO USE

Under a Federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, as amended, group health plans must generally comply with certain requirements. However, the law also permits state and local governmental employers that sponsor health plans to elect to exempt a plan from these requirements for any part of the plan that is "self-funded" by the employer, rather than provided through a health insurance policy. A group health plan may not discriminate in enrollment rules or in the amount of premiums or contributions it requires an individual to pay based on certain health status-related factors: health status, medical condition (physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, and disability. **The sole differentiation among enrollees in the Commonwealth's Plan relates to the incentive, through a greater employer contribution, offered to enrollees that refrain from the use of tobacco products. No other health-related factors are used to distinguish enrollees.**

E. COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1986, or COBRA, provides that virtually all employers who sponsor group health plans must permit covered individuals, who lose coverage under that plan as a result of certain enumerated events, to elect to continue their coverage under the plan for a prescribed period of time on a self-pay basis. Individuals who are entitled to COBRA continuation coverage are known as Qualified Beneficiaries. **Under federal law, you must have 60 days after the date of the COBRA qualifying event or date you lose benefits due to a COBRA qualifying event to decide whether you want to elect COBRA continuation coverage under the Plan.** The KEHP's third-party COBRA administrator is Ceridian COBRA Continuation Services.

F. THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA)

The Women's Health and Cancer Rights Act of 1998 is a federal law that provides protections to patients who choose to have breast reconstruction in connection with a mastectomy. This federal law requires insurers offering individual health insurance coverage, as well as all group health plans, which provide medical and surgical benefits with respect to a mastectomy, to provide in a case of an insured who is receiving benefits in connection with a mastectomy.

G. MENTAL HEALTH PARITY

The Mental Health Parity Act provides for parity in the application of aggregate lifetime and annual dollar limits on mental health benefits with dollar limits on medical/surgical benefits. A plan that does not impose an annual or lifetime dollar limit on medical and surgical benefits may not impose such a dollar limit on mental health benefits offered under the plan.

H. NEWBORNS' AND MOTHERS' HEALTH PROECTION ACT

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

I. HIPAA PRIVACY NOTICE

This Notice describes the obligations of the Commonwealth of Kentucky, Personnel Cabinet, Kentucky Employees' Health Plan and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law. We are required to provide this Notice of Privacy Practice to you pursuant to HIPAA. The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, health care clearing house, or your employer on behalf of a group health plan that relates to: 1) your past, present, or future physical or mental health or condition; 2) the provision of health care to you; or 3) past, present, or future payment for the provision of health care to you.

Please note that the Kentucky Employees' Health Plan maintains demographic, protected health information. Any member will need to contact Humana, Inc. or Express Scripts, Inc. for information relating to payment of claims and services provided under his/her health plan.

If you have any additional questions about this Notice or about our Privacy Practices, please visit http://personnel.ky.gov/dei/hipaa.htm.

Commonwealth, Personnel Cabinet Responsibilities: We are required by law to: 1) maintain the privacy of your protected health information; 2) provide you with certain rights with respect to your protected health information; 3) provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and 4) follow the terms of the Notice that is currently in effect. We reserve the right to change the terms of Notice and to make new provisions regarding your protected health information that we maintain, or as required by law.

How Commonwealth, Personnel Cabinet May Use and Disclose Your Protected Health Information: Under the law, we may use or disclose your protected health information under certain circumstance without your permission. The following categories represent the different ways that we may use and disclosure your protected health information: 1) **For Treatment**. We may use or disclose your protected health information to facilitate medical treatment or services by providers. 2) **For Payment.** We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for treatment or services your receive from health care providers, to determine benefit responsibilities under the Plan, or to coordinate coverage. 3) **For Health Care Operations**. We may use and disclose your protected health care information for other Plan operations. 4) **To Business Associates**. We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. An example would be this Plan's Third Party Administrator Humana. 5) **As Required by Law.** We will disclose your protected health information when required to do so by federal, state or local law. 6) **To Avert a Serious Threat to Health or Safety**. We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. 7) **To Plan Sponsors.** For the purpose of administering this Plan, we may disclose to certain employees of the Commonwealth, Personnel Cabinet protected health information.

Special Situations: In addition to the above, the following categories represent other possible ways we may use and disclose your protected health information: 1) organ tissue donation; 2) military and veterans; 3) workers' compensation; 4) public health risk; 5) health oversight activities; 6) lawsuits and disputes; 7) law enforcement; 8) coroners, medical examiners and intelligence activities; 9) inmates; and 10) research.

Required Disclosures: The following represents disclosures of your protected health information we are required to make: 1) Government audits; and 2) disclosures to the participant (you).

Other Disclosures: Other disclosures may be made to your personal representatives, spouses and other family members and with written authorization.

Participant Rights: A participant has the following rights with respect to their protected health information: 1) right to inspect and copy; 2) right to amend 3) right to an accounting of disclosures; 4) right to request restrictions; 5) right to request confidential communications; 6) right to be notified about a breach of unsecured PHI; and 7) right to a paper copy of this Notice.

Complaints: If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office of Civil Rights of the United States Department of Health and Human Services at http://www.hhs.gov/ocr/office/index.html. To file a complaint with the Plan please visit http://personnel.ky.gov/dei/hipaacontact.htm. All complaints must be in writing. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office of Civil Rights or with this Plan.

J. INFORMATION ABOUT MEDICARE SECONDARY PAYOR

Employer group health plans, like KEHP, must pay primary to Medicare for employees who are eligible for the employer's group health plan by reason of their current employment status. If a retiree returns to work and the retiree works enough hours to qualify for coverage under the employer's group health plan for active employees, the federal regulations require the employer to treat the retiree as an active employee for purpose of Medicare Secondary Payor. The employer may offer a Medicare eligible active employee a choice between receiving coverage under the group health plan or opting out of the employer's plan and receiving coverage exclusively from Medicare. If the active employee opts for the employer's plan the employer may not offer the employee any group health coverage that supplements Medicare.

K. PLAN YEAR 2011 KEHP PRESCRIPTION DRUG COVERAGE AND MEDICARE

The Kentucky Employees' Health Plan has determined that the prescription drug coverage offered by the Kentucky Employees' Health Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

L. NEW FEDERAL LIMITS ON USE OF FSA and HRA FUNDS

Pursuant to the Patient and Affordable Care Act, as amended, effective January 1, 2011, the cost of over-the-counter medicines (other than doctor prescribed and insulin) may not be reimbursed through a health flexible spending accounts (FSA's) or health reimbursement accounts (HRA's). Note that there are some exceptions to these federal limits.